HISPANIC CULTURAL INFLUENCES ON MEDICAL PRACTICE

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Because the proportion of Hispanic patients is increasing rapidly, most physicians are now coming into daily contact with Hispanics. In addition to obvious difficulty with oral communication, Hispanics share characteristics, in varying degrees, that may interfere with their search for medical help, the diagnoses of their illnesses, therapy, and health education.

Neither physicians nor other health professionals need to be experts on Hispanic culture or language to be able to assist Hispanic patients properly. This article summarizes the ethnic background, beliefs, and approaches to health commonly noted among Hispanic patients. Their commonly held assumption that they are in this country only temporarily prevents successful acculturation efforts. Non-Hispanic physicians can nonetheless find great satisfaction in providing quality care for their Hispanic patients.

Plurality is a way of life in this country. The United States is a nation of nations, and the proportion of Hispanics has been increasing significantly in recent years. For instance, the Hispanic population in the United States is the sixth largest in the world. It has been estimated that by the year 2000, 25 percent of the Chicago population will be Hispanic.[1] In addition, the Immigration and Naturalization Service (INS) estimates that 25 percent of the 3.5 million-per-year undocumented aliens in this country are Hispanic. Even though this proportion varies by the time of year because many Hispanics are seasonal workers (eg, farm workers, landscapers, industrial workers), most physicians and other health professionals are in daily contact with patients with a Hispanic background.

Currently, the number of Hispanic physicians is not adequate to provide medical care to the ever enlarging Hispanic population. Despite their cultural bond with Hispanic physicians, many Hispanics still prefer non-Hispanic physicians because they often assume that a physician born and trained in America is better. The purpose of this article is to inform physicians and other health workers about some of the cultural characteristics that might influence their professional contact with Hispanic patients.

HISPANOS

The term "Hispanos" has cultural connotations rather than ethnic ones. Because of multiple interracial unions throughout the centuries, predominant ethnic characteristics are lacking among Hispanics. Their ethnic backgrounds are mixed. Hispanics are persons who share certain characteristics, such as country of origin (Latin America, Spain, and other Spanish-culture countries) and the Spanish language.[2] Most Hispanics are also Catholic. Latins are people who originate from

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countries where the modern language was derived from Latin, eg, Spain, France, Italy, and Portugal. Thus, Hispanics are Latins, but Latins are not necessarily Hispanics.

Most Hispanics in the Chicago metropolitan area are of Mexican ancestry (60 percent); and a significant number originate from Puerto Rico (15 percent), Cuba (7 percent), and South America (18 percent). These proportions are maintained nationwide.

Persons who share these characteristics may choose, for whatever reasons, not to be considered Hispanic. Immigration to the Hispanic countries was intense until early in this century; and although many persons share this common origin and language, they may have preserved their original ("old country") cultural ties and do not consider themselves Hispanics. Some Hispanics may consider themselves absolutely adapted to their new country and have chosen to completely sever previous cultural ties. These attitudes vary according to the years they have lived there and to the relative negative societal attitudes toward a specific cultural subgroup. Furthermore, a Spanish surname is not necessarily associated with a Hispanic person, as many might assume. Thus, one may prevent misunderstandings by asking a person whether he considers himself Hispanic.

Despite their common origin, Hispanics are very individualistic. Regional differences often separate individuals, even those who are from the same country. Large groups of Hispanics had been settled, especially in the southern portions of this country, before the states they resided in became part of the Union. Around World War II many others arrived in this country as temporary workers ("migrant workers"). Even now a large proportion of Hispanics believe they are in this country only temporarily. Some Hispanics who come to this country from farms might never have seen a small city before.

Not all migrant workers are farm workers. During the last few decades, professional and other specialized workers have been arriving in this country from all over the world because the United States is still regarded as the land of opportunity and freedom. Unless individuals come to this country to further their education and training, improving their ability to communicate in English may not be a high priority for them, even after many years have elapsed.

WHAT'S IN A NAME?

This less-than-ideal ability to communicate in English may not be the only challenge that the health worker caring for Hispanics might encounter. There might even be difficulty in registering them. Traditionally, most Hispanics have a four-word name. For example, Juan Pablo Garcia Perez is Mr. Garcia Perez or Mr. Garcia, but not Mr. Perez. His mother's family name (Perez) is placed last; a family name will be lost after two consecutive generations of women. Still, Miss Maria Luisa Garcia Perez becomes Maria Luisa Garcia Perez de Sanchez when she marries Mr. Carlos E. Sanchez, not Mrs. Maria L. Sanchez, much less Mrs. Carlos E. Sanchez, as women are sometimes addressed in this country. Even today, a patient's chart might need to be changed later on because the patient might not have originally included her husband's last name as hers. This confusion may become even more complicated when the patient chooses her second name as her first name or has more than four given names and surnames, including hyphenated compound names. The situation sometimes becomes difficult when writing a birth certificate, considering that about 80 percent of Hispanics do not speak English.

Also, in this country, when a signature is required, one is supposed to write one's name (with adequate spelling). Among Hispanics, the signature represents something very individualistic—it doesn't necessarily have any resemblance to one's name. The Hispanic feels he must try to be original—must write something that almost nobody else could duplicate. However, in this country, when Hispanics sign a document, a check, or a credit card receipt, it might not be honored because the salesperson expects to see a clearly written name.

COMMUNICATIONS

Although nonverbal communication is an important part of the patient-health worker relationship, expertise in the patient's language is a great asset. Most patients are very grateful for our efforts to communicate with them in their maternal tongue. The use of mental health facilities, for example, improves when bilingual and bicultural personnel are available. The language people use

as children continues to be the language they use with family and friends, the language they use under stress or when exhausted, and the language they identify with happy situations.[3] In emotional situations such as those involving their health, then, they can communicate much more easily with someone who understands their first language.

Even among persons who speak the same language, communication difficulties occur, depending on the country of origin (eg, British and American English), the region (eg, Boston and West Virginia), the use of slang, the level of education, and the occupations of the speakers. Similar objects or actions may be given different names. For instance, the language employed by physicians, lawyers, bus drivers, bricklayers, and sportscasters while they are involved in their individual occupations is very specific and characterizes each as a member of a specific group. An outsider to the group will have to become familiar with the daily language employed to avoid difficulties in comprehension. All of these varied influences should also be noted when treating Hispanic patients. In addition, one must acknowledge that a good segment of the current Hispanic population uses a hybrid dialect—a mixture of English and Spanish[3]—that requires a working ability in both languages to communicate with them.

When discussing problems, advising about therapeutic alternatives, and educating patients about their medical conditions, physicians usually present information that is new to patients. Physicians translate this information into layman's terms suitable to each patient's level of sophistication and understanding of the specific disease. Several factors influence this exchange, eg, a patient's personal concerns, anxieties about threats to life, future plans, the possibility of pain or disfigurement, and current difficulties including interpersonal problems. A physician's bias about specific treatments, consideration about prognosis, pressure for time, and assumption that the patient is listening and following the conversation also affect this communication.

One study reported a low recall by patients of specific information given to them before surgery. These patients were surprised when they saw themselves on the videotape, apparently participating in the discussion in which the information was provided. If average patients can recall very little about information provided when delivered under controlled conditions by physicians and counselors with similar backgrounds and in their native languages, it is no wonder that a language and a cultural barrier creates difficulty. Another difficulty in assisting Hispanic patients is that many come from rural areas and lack the sophistication gained from being raised in an urban setting. Often, more than medical advice needs to be provided, eg, instructions about the city and its institutions, assistance on settling, and advice about jobs and obtaining food. Often one might even become an advocate in situations regarding patients' rights when marginal abuse is noted.

Still, the ability to communicate in a "neutral" language (one that does not have specific national and regional variations) is very well regarded in the advertising media.[4] However, in the health area, perhaps because it is more intimate, specific knowledge of the regional and national variations is often required to achieve maximal communication. An object, a disease, or a piece of clothing may have different names in different countries and confusion may be created.

Another Hispanic peculiarity, perhaps due to the emphasis on the respect for authority, is the apparent acceptance of what the health worker (or any other person) is saying. Sometimes when one does not understand, it is easy to say "yes." However, the nodding and affirmative expressions among Hispanic patients are not necessarily associated with acceptance. They must be asked to repeat what they have understood.

During the process of acculturation, one usually understands English long before one can express it. Comprehending common expressions, slang, jokes, and statements with implied or double meanings takes even longer. Written communication is easier to understand than oral communication, even though the individual may observe gestures and the intensity of the speaker during the conversation. The reader has more time and may use a dictionary to comprehend. Expressing oneself clearly in English may be a lifetime effort and our accents tend to stay with us forever. Expressing oneself in a second language also requires assistance. Finally, it must be remembered that not everyone is able to comprehend written material as well as it may seem. There are some persons who can communicate only orally. Even in this country, considered to be the most advanced in the world, the average level of reading for the

public is sixth grade, so our communication must be at that level as well.

TRANSLATORS

Most well-meaning persons assume that a translator can eliminate the language barrier. A good translation should say what the original speaker meant to express. A literal translation is often worthless. "I have 25" does not mean "I am 25." However, the age of the patient is the second most common question asked after the patient's name. Often, signs in important places that are translated literally may provide confusing and often misleading information. Other problems may occur with individual translators. First, there is the difficulty with the level of communication in both languages, as previously mentioned. Second, a translator is usually placed in a superior position, supposedly knowing both languages, and therefore knowing more than the professional and the patient. Third, no two observers of the same phenomenon will report it identically. Fourth, even the dictionary definition of translation implies a personal interpretation of the facts. Thus, the individual translator's beliefs (moral, ethical, or otherwise) influence what he hears and subsequently tells the patient. Occasionally, the information provided to the patient is distorted, even though there was no deliberate attempt to change the facts. Finally, the professional restrictions and duties that professional ethics place upon physicians do not apply to lay and other persons doing the translation for the patient.

Although bilingual and bicultural assistants or secretaries are sometimes difficult to find, they provide the best cooperation. Physicians may instruct them and observe them delivering to patients the message they have been trained to deliver. If the same message gets delivered several times, it will have more impact and will positively affect the patients. Clear statements made by such health care facility workers, whatever their level in the health care hierarchy, have more influence on the patient than the one given by the medical director in another language or with detachment. These authority figures may have a great impact on health education and management of medical problems by providing good role models, but it is better to teach by doing than by preaching.

HEALTH RISKS

There are no health care data available on Hispanic persons. The only available information refers to predominantly Hispanic areas (at least 33 percent Hispanic), not to pure Hispanic populations. Recently, the city of Chicago included on its birth and death certificates the item "Hispanic." This approach might help provide adequate information on which to base rational policy.

Considering the limitations of the available information, urban Hispanics seem to be younger on average than the rest of the population (20.3 years vs 30.5 years); they have more children per family (4.4 persons compared with 3.5), low perinatal mortality, and fewer premature births.[1] The incidence of chronic diseases such as heart disease and cancer is lower; however, cirrhosis of the liver and homicides are more common. Hispanics have a higher incidence of childhood diseases, newborn pneumonia, hepatitis, lead poisoning, and infectious diseases in general.[1] The fate of migrant workers is worse. Their life expectancy is 49 years (compared with 74.1 years nationally); their morbidity and mortality is two to three times the national average. Alcoholism causes high morbidity and mortality; in fact, Hispanics' alcoholic complications are two to three times the national rate, and this does not consider the related effects on the close family members.

In California, more than 50 percent of Mexican-American deaths are associated with cirrhosis of the liver. According to several studies, more than half of the men have been or are affected by excessive alcoholic intake. To those affected by factors such as cultural isolation and "machismo," alcohol sometimes seems to be the only distraction. It serves as a means of coping. In 1980 a rural program in Anna, Illinois, almost eliminated alcoholism among migrant farm workers by actively searching for potential patients, providing alternative distractions (soccer games, picnics, and plays), and communicating the consequences of alcohol abuse on the family and society. Drug abuse, diabetes mellitus, and arterial hypertension are also other pressing medical problems among Hispanics. For cancer there are higher age-adjusted mortality figures, possibly due to late diagnosis associated with misinformation and reticence to search for early and adequate medical help.

Hispanics face multiple difficulties in their new chosen land. Often Hispanics have no choice as to where they may seek medical care because of inadequate roots (no contacts, transient status), misinformation, and socioeconomic factors. Most Hispanics have poor income, overcrowded housing, limited facilities and services, poor schooling, little contact with professionals, and inadequate role models. Red tape and some of the problems of clinic operations, such as early closings and large amounts of paperwork, may further interfere with their search for adequate medical attention. Because of their immigrant status, Hispanics may be afraid of the clinical staff and may consider them members of a government agency such as INS. The system they were accustomed to before arriving in this country includes lay practitioners, lay midwives, and healers. Often they tend to solve their medical problems at home with the assistance of elders, family members, friends, and neighbors. Later they try the medical system they are accustomed to before venturing into the uncharted areas of the new land.

HEALTH BELIEFS

For most people, good health is a blessing not usually appreciated until it is lost. An adequate state of health allows us to be productive and provide for the family. Among Hispanics, the support provided by the extended family is very important. Personal and interpersonal family problems tend to be resolved within the confines of the family, which stimulates pride and provides satisfaction. These close ties with members of the extended family may be lost because of migration. Often close communication is kept by telephone, mail, and short-stay trips. Close family ties have been considered an important factor in the lower utilization of mental health services by Hispanics as compared with other groups.[3] There is also a certain resistance toward psychological counseling. Many Hispanics believe that one must be completely disturbed to require such services and that one must try to help oneself. As becoming sick is considered a weakness, intimate thoughts and concerns are shared only with very close persons (such as mothers or spouses). Men are not supposed to complain, so they do not talk or freely express intimate feelings unless they are among close friends. Home and family problems should not leave the home environment. Disappointments and feelings of betrayal would be justified if this kind of information were allowed to become general knowledge. These attitudes tend to limit the discussion and solution of problems to the confines of the close family and exclude the help of professional counselors.

Health professionals must also realize that they do not identify the same health risks as patients do. Sophistication among the public about health in general increases this area of knowledge among patients. Smoking, rectal bleeding, increased salt intake, etc, are commonly accepted by most people as health risks. Some health risks are identified only by health professionals (eg, domestic cats may represent a serious risk for a pregnant woman; routine douching is dangerous). However, there are also health risks identified only by some patients (myths, beliefs, folk diseases).[5] As emphasis is placed on public education, health professionals must also learn about the specific beliefs that may distort patients' understanding of health problems and will affect compliance with therapeutic measures.

An open attitude toward patients' beliefs about their reasons or explanations for their distresses and illnesses provides health workers with many avenues for adequate diagnoses. Listening to patients and showing respect for their opinions and beliefs also encourages their participation in their treatment plans, and usually leads to better compliance. There is no need for the physician to be an expert in folk diseases, but awareness and a nonjudgmental attitude facilitate patients' expressions of their beliefs. One may learn about dangerous treatments, innocuous therapies, or rituals that may be allowed to continue. On the other hand, one may prevent patients from being abused by unscrupulous individuals and jeopardized by extreme therapies. These beliefs and attitudes may go unnoticed if open communication is not allowed.

Some Hispanic persons believe that there are some diseases that can be handled only by the healer ("curandero") in certain specific rituals. This type of person tends to believe that physicians and their medicines would only do further harm—that "spells," "fright," or the "evil eye" could be fatal if not attended to in time.[3] The healer is thought to discover what the person has

done to expose himself or to provoke the problem. He usually knows what is wrong without even asking. Many people, when not feeling well, utilize prayers, supernatural assistance, or even lay practitioners (friends or healers), before seeking medical assistance. Although some may return to healers and other alternatives when not satisfied with modern medical care,[5] others employ both methods at the same time.

The concepts of "hot" and "cold" often have an influence on Hispanics. These concepts assign food and natural agents a hot or cold effect in the human body. A sudden change from one group to the other, or an excess or deficiency of one agent or the other may cause serious disturbances in the body. As the list is long and not every believer necessarily has a similar classification, the health worker may approach the patient by asking whether it would be appropriate to follow a proposed management. Questions may arise, for instance, about giving ice to a child with a fever or even about eating hot pepper or fish after surgery, bathing following delivery, and so on. When the patient is reluctant to follow advice, adequate, more acceptable alternatives may be offered. Gently, unscientific attitudes may be changed.

Because virginity and the ability to bear children still have outmost importance, most single women will not submit to pelvic examinations except in life-threatening situations. Many myths and misinformation about family planning are apparent; but, in this respect, Hispanic beliefs are similar to those of the population in general.

As there is much veneration of the Hispanic mother, there is respect for paternal authority too, even when decisions are made about matters in which the wife or children may have acquired more knowledge. Men, as in other cultures, are more reluctant to search for medical assistance. This is true to an even greater extent when a gynecologist needs to evaluate the couple for infertility or sexual problems. Although a postcoital test may obviate the man's reluctance to submit to a semen analysis, the management of a sexual problem becomes more difficult without his participation.

Among Hispanic families, the father/husband usually makes final decisions, including those about health matters. As with other patients, the family must be involved in the decision making in order to improve patients' compliance. Younger family members will pay more attention to their mother's and father's advice than the physician's. Early involvement of the father/husband during education and counseling will improve health workers' efforts. The participation of the father/husband is vital to the successful management of an individual family member's problems.

Among Hispanics, the preferred patient-physician relationship is of authoritarian-paternalistic type ("You are the doctor; you will do what is best for me"). The presentation of alternatives for treatment, although required by law and common sense, may be considered evidence of weakness by Hispanic patients, as well as an indication of a physician's poor knowledge and poor performance. They may search for another physician who will tell them what to do, although younger people and patients who have been in this country longer are becoming more knowledgeable in their new country's ways, and often request participation in the decision-making process regarding their health.

Generalizations are unwarranted, especially those in regard to persons. The author has tried to express some of the characteristics that members of the Hispanic group tend to share by the bond of cultural pride, though at different levels of sophistication. Providing medical care for them has many advantages. Among the advantages noted in treating Hispanics are their respectfulness, their expressions of gratitude (by acknowledgment or gifts), and their pride in paying their fees.

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